South Carolina
Department of Disabilities and Special Needs
Service Coordination Manual

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Scope and Intended Use:

This manual is intended for use by Service Coordinators, Early Interventionists and administrative staff of all Service Coordination providers who contract with the South Carolina Department of Disabilities and Special Needs or Department of Health and Human Services (DHHS) to set forth the minimum requirements for Service Coordination.

Prepared By:

The SCDDSN Office of Service Coordination, with input and information from people eligible for DDSN services, SCDDSN staff, Service Coordinators employed by DSN Boards and qualified providers and staff who provide other services from around the state.

Technical Assistance:

Requests for technical assistance regarding Service Coordination Service should be directed to the appropriate SCDDSN District Office.

Additional Copies:
Excerpts of this manual can be obtained from the SCDDSN Internet Web Site and/or by request from the SCDDSN Office of Service Coordination (803) 898-9715.

South Carolina
Department of Disabilities and Special Needs
Service Coordination Standards

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CHAPTER 1

INTRODUCTION TO SERVICE COORDINATION

I. WHAT IS SCDDSN SERVICE COORDINATION?

The mission of SCDDSN is to assist people with disabilities and their families through choice in meeting needs, pursuing possibilities and achieving life goals and minimize the occurrence and reduce the severity of disabilities through prevention. Consistent with the agency's mission, the intent of DDSN Service Coordination is to assist people with Mental Retardation/ Related Disability (MR/RD), Autism, and Head and Spinal Cord Injuries and Similar Disability (HASCI) to access a full array of effective and cost efficient services and supports that are needed in order to avoid costly residential placement thereby making it possible for people to reside in their own homes and communities.

It is expected that SCDDSN Service Coordination services be provided in a manner that promotes:

- dignity and respect
- health, safety and well-being;
- individual and family participation, choice control and responsibility;
- relationships with family and friends and community connections;
- personal growth and accomplishments.

It is also expected that Service Coordination services reflect the principles of the agency and therefore services should:

- be person centered
- be responsive, efficient, and accountable;
- be strengths-based, results oriented;
- maximize potential; and
- be based on best and promising practices.

II. THE ROLE OF THE SERVICE COORDINATOR

The Service Coordinator is responsible for coordinating services to assure that people have access to a full array of needed community services including appropriate medical, social, educational or other needed services. The Service Coordinator is responsible for identifying the person's needs and resources, coordinating services to meet those needs and monitoring the provision of those needed services. More specifically, the service coordinator's job is composed of the following core functions:

- **INTAKE -** performing activities that lead to the enrollment of someone into the service delivery system. Activities include completing a home visit to conduct a face-to-face interview with the person applying for services/legal guardian; gathering information that may support DDSN eligibility from the person /legal guardian, family members, current and former service providers and others who know the person; and completing an Application for Eligibility (see attachment) packet for submission to the SCDDSN Consumer Assessment Team (CAT) for review. Other reportable activities may also occur during intake such as a referral to a non-DDSN service provider to address an immediate need.

- **NEEDS ASSESSMENT** – activities to obtain and review information in order to determine the strengths, preferences, resources and needs of the person and family. Activities include the completion of a standardized assessment as well as reviewing and evaluating assessments gathered from other sources. Needs assessment activities may also include reviewing information for or preparing a Level of Care re-evaluation to determine if a person continues to meet the ICF/MR Level of Care or Nursing Facility Level of Care.

- **PLAN DEVELOPMENT -** activities include coordinating information for and communication between the person receiving services/legal guardian and others who are important in the life of the person who will participate in developing the Support Plan. Plan development activities may also include setting up a plan meeting, notifying plan participants of the meeting, facilitating and/or participating in the plan meeting, writing the Support Plan document, and implementing the plan.

- **PLAN IMPLEMENTATION** – activities involve assisting a person receiving services or legal guardian in identifying an appropriate provider for a needed service, working to develop a new resource to meet a person's needs, arranging and authorizing services with chosen providers, completing budget and/or plan revisions to address changes in a person's needs, and reviewing/reconciling a person's budget at the end of the fiscal year to assure adequate and appropriate funding is in place to meet identified needs.

- **CRISIS INTERVENTION** - response to specific needs which if not met would cause the person to be in jeopardy and which would require immediate resolution; activities include the immediate assessment of a crisis situation; making phone calls, visits or other contacts with the person receiving services/legal guardian or providers to address an identified problem and assure follow through; reporting any critical incidents, abuse or neglect issues; and following up.

- **ADVOCACY** – activities involve supporting the basic human rights of people and families; assuring fair and equal access to environments and any necessary services including educational needs; assuring quality of services being provided; and assuring basic health and safety needs. Advocacy should be on behalf of a specific person receiving services, although systems change may also be a result.

- **CONSULTATION/COLLABORATION** – activities involve conferring with service providers and other professionals to gain a better understanding of a person's current situation and to determine the best course of action to address identified needs.

- **MONITORING** – determining if the plan is effective; activities may include face-to-face contacts with the person receiving services and or legal guardian; home visits; evaluation of services as they are being provided; mail correspondence, telephone calls, e-mail and fax correspondence with the person, legal guardian, family, providers of services and supports received and appropriate others; quarterly plan reviews; and monitoring as required by the PDD, MR/RD and HASCI Waivers. (Please refer to the PDD, MR/RD and HASCI Waiver Manuals/guidelines for more information about monitoring requirements.)

III. KEY SKILLS FOR SERVICE COORDINATION

Service Coordinators must possess many skills and abilities in order to provide quality services and to effectively perform the core functions of the job. The key skills for Service Coordination include those interpersonal skills that are needed to establish relationships with others including:

The ability to actively listen– to actively seek information from someone; to hear what and how something is being said; to communicate with and learn from another or from group reviews, written feedback, personal outcome interviews, etc.; to respect people served by allowing them to decide when and where communication takes place.

The ability to respond – to take information received about a person and assist in finding resources/services/supports to respond to needs; to respond to immediate requests (i.e. respond in a respectful and timely manner upon verbal requests, to respond to telephone calls immediately, respond in providing information to others, making timely referrals, etc.).

The ability to respect the person's perspective and experience – to be empathetic; to seek to understand the person before making recommendations for services; to give the person the same dignity, rights, and honor as other members of the community; assist people in exercising their rights that will facilitate personal goals.

The ability to resolve conflicts - be an effective mediator.

The ability to provide relevant information - to provide information that is concrete and specific enough to enable people to make informed decisions; facilitate visits, observations and experiences for people so informed choices can be made; having knowledge of local, state, federal, and community resources to be able to offer an array of choices.

The ability to promote natural support relationships – to assist in promoting or developing relationships that enable and encourage people to identify their goals and improve their lives; assist in establishing a support network that goes beyond typical/paid services/supports.

The ability to mange competing priorities – to be able to manage work where there are unpredictable situations such as when needs develop, crisis situations occur, etc.

The ability to think critically – to be able to think about situations and respond to them or provide solution, to make professional judgments based on an array of information

IV. PERSON-CENTERED APPROACH AND PLANNING

A person-centered approach is a strategy that, when employed, allows the Service Coordinator to learn about a person with disabilities in order to support that person to create a lifestyle that allows him/her to fully participate as an active citizen who contributes to the life of the community. A person-centered approach is more than a meeting; it is a system of beliefs and values employed when people work together (person with the disability, legal guardian, friends, staff, etc.) to assist with the creation of a lifestyle based on the person's needs, interests and preferences. In other words, the focus of person-centered approaches should be to assist a person receiving services to have a meaningful life as they define it, which requires more than merely accessing services. All planning that occurs on behalf of people served should be person-centered. The group of people assembled to work with the person/legal guardian is commonly known as the 'circle of support,' which includes people that the person receiving services/legal guardian desires to be involved in the process. A circle of support might include the person served, friends, neighbors, family, Service Coordinator, service providers, other professionals who work with the person being served and any other natural supports that are meaningful in their life.

Today many people with disabilities are seeking more control over their lives. Their focus is on choice and self-determination in all areas of life, but especially in those that affect friends, neighbors, home, work, finance and leisure. Ideally, people receiving services should be directing their lives. People with disabilities have the right to determine their personal goals, the responsibility to share those goals with professionals when assistance to attain them is desired, and the right to decide which services and supports they want to meet their needs. These services and supports include natural and community resources, as well as traditional agency services.

Some people with disabilities are capable of identifying and obtaining supports and services on their own. Others have family members, friends, and other natural supports to help them. However, many people with disabilities and their families prefer professional assistance in developing a plan, which is part of the type of assistance that Service Coordinators can provide.

Service Coordinators help people receiving services explore what they want and need in life. They work in partnership with the person/legal guardian to develop, implement, monitor and maintain the person's plan. Service Coordinators assist people to attain the highest quality of life as defined by them. Two activities of Service Coordination that are especially critical deal with protecting and upholding a person's human and civil rights and assuring their health and safety needs.

While the Service Coordinator is responsible for the development and implementation of the annual plan, it is the person receiving services and/or legal guardian who guide the Service Coordinator in identifying and fulfilling needs. In order for this to happen, the Service Coordinator must develop and maintain a relationship and partnership with the person receiving services and/or legal guardian, come to know the person's personal goals and needs, and be able to advocate for the person. It is this personal relationship with the person receiving services and/or legal guardian, and the positioning of the person in the driver's seat that is at the heart of person-centered planning.

CHAPTER 2
STANDARDS

I. Staff

Standards	Guidance
1.Service Coordination services shall be rendered by qualified staff: ***A. Service Coordination Supervisors (SCSs)*** **must hold a Master's degree in Social Work or a related from an accredited university or college and have at least one year of experience in programs for people with disabilities or have at least one year of experience in a case management program and demonstrate knowledge of disabilities** **OR** **Hold a Bachelor's degree in Social Work or a related field from an accredited university/college and have at least 3 years of experience working with people with disabilities or have at least 3 years experience in a case management program and demonstrate knowledge of disabilities.**	
B. Service Coordinators(SCs) **must hold at least a Bachelor's degree in Social Work or a related field from an accredited college or university** **OR** **Hold at least a Bachelor's degree in an unrelated field from an accredited college/university AND have at least one (1) year of experience in programs for people with disabilities or have at least one in a case management program and**	Activities of Service Coordinators who do not meet qualifications are NOT reportable, Exceptions will not be granted for staff who does not meet the required qualifications.

Standards	Guidance
demonstrate knowledge of disabilities. ***C. <u>Service Coordination Assistants (SCAs)</u> must hold* a high school diploma/GED (or higher) and must have the skills and competencies sufficient to perform the tasks to which they may be assigned or the capacity to acquire those skills and competencies.**	Activities of Service Coordination Assistants who do not meet the qualifications and whose documentation is not co-signed by a Service Coordinator/ Service Coordination Supervisor are <u>NOT reportable</u>, Exceptions will <u>not</u> be granted for staff who does not meet the required qualifications. The activities of a Service Coordination Assistant are primarily administrative or clerical in nature. Duties performed by an Assistant in support of Service Coordination may include the following: 1. General clerical duties such as filing, copying, faxing, typing, etc. 2. Identification of resources to meet individuals' needs. 3. Responding to requests for information and referral. 4. Accompanying Service Coordinators to interagency staffing, intra-agency staffing, IEP meetings and other meetings. 5. Gathering records and information and submitting eligibility requests and requests for Level of Care evaluations including tracking service delivery due dates. 6. Gathering records and information to begin completion of the Service Coordination Annual Assessment. 7. Identification and recruitment of caregivers. 8. Reviewing and reconciling waiver budgets and expenditures. 9. Monitoring consumer satisfaction 10. Annual contacts with consumers on Level II and Optional Service Coordination. Service Coordination assistants may not: -Complete Assessments. -Develop Service Plans. -Report activity on the Service Provision Log (SPL). -Attend interagency staffing and meetings (though a Service Coordination Assistant may accompany.) -Attending court ordered hearings or other legal

Standards	Guidance
	proceedings (though a Service Coordination Assistant may accompany.) -Develop waiver budgets and revisions. -Complete reevaluations of ICF/MR Level of Care -Have a caseload of DDSN eligible people. (Assistants may have a caseload of non-eligible people during Intake.)
2. Each Service Coordinator / Supervisor must be an employee of SCDDSN, a DSN Board, or a SCDDSN qualified Service Coordination provider	
3. Documentation must reflect a choice of Service Coordination provider was offered: **a. to all people (guardians of minors) continuing to seek eligibility for SCDDSN services after screening** **b. annually to those who are eligible.** **c. when requesting a change of provider**	Service Coordinators must inform applicants of all available Service Coordination or Early Intervention providers and offer them a choice of providers. The screener will document the person/legal guardian's choice on the Screening Disposition Form. (Please refer to the SCDDSN Screening Tool and Procedures for a copy of this form.) The choice of provider must be documented on the "Acknowledgement of SC/EI Choice" form If the person does not choose to change providers at the annual review, it will not be necessary to obtain a new "Acknowledgement of SC/EI Choice form". The current Service Coordinator will document that a choice was offered. Requests for a change in provider must be honored in a timely manner and documentation must reflect that a choice was offered**.**
4. Each Service Coordination provider shall maintain: **a. a current list of staff members** **b. signature sheet** **c. credentials folder for each staff member which includes:** **-Resume'/Equivalent Application** **-Certified copies of transcripts from an -accredited university /college** **-Training records** **-Job description** **-Annual performance evaluations** **-SLED and DSS central registry checks**	

Standards	Guidance
5. A. Service Coordination staff must be provided training and must demonstrate competency in the following topic areas: **- SCDDSN Service Coordination Standards** **- SCDDSN policies and procedures applicable to Service Coordination** **- Rights** **- Local, State, and Community Resources** **- Access to and use of CDSS/STS** **- Nature of MR/RD, Autism, traumatic brain injury, spinal cord injury and similar disability (as appropriate)** **B. Newly employed Service Coordinators with at least a Bachelor's degree in a field of study <u>unrelated</u> to Social Work must have a minimum of 60 <u>hours</u> of training during the first year of employment. The training should include at least 20 hours of agency and 40 hours of training specific to Service Coordination core functions.** **C. Newly employed Service Coordinators with at least a Bachelor's degree in Social Work or a <u>related</u> field must have a minimum of <u>40 hours</u> of training in Service Coordination related topics during the first year of employment.** **D. Newly employed Service Coordinators with prior experience as a Service Coordinator with a DSN board or DDSN qualified service coordination provider or with prior experience in a Medicaid funded case management**	Records must reflect that information presented was comprehended by the Service Coordinator. From time to time, the provider may require an experienced Service Coordinator to have additional training on a topic in which additional knowledge or enhanced skills are needed. Both topics and quantity of training in these instances are at the discretion of the provider. Service Coordination related topics' refers to any training directly related to the core job functions of Service Coordination (e.g. waiver training, Support Plan training, assessment training, HIPAA, etc.) or any training that will support or enhance a core job function of Service Coordination (e.g. communication /interviewing, resource development, CDSS use, etc.). Required training hours are not limited to a classroom setting. Time spent shadowing a veteran Service Coordinator, the initial reading of Service Coordination Standards or manuals, one-on-one supervisory meetings, etc. can be counted toward required Service Coordination training hours. The Supervisor and/or Executive Director may require additional training on specific topics and in amounts at their discretion. SCDDSN policies and procedures include Level I/Level II Service Coordination, Assessment and Plan, Eligibility, Waiver (if applicable), QPL Procedures, Abuse and Neglect, Critical Circumstances/Waiting Lists, DDSN Services/Supports, Documentation, Family Support Fund Stipends, etc. Service Coordinators should understand and know all of the services and supports available to address needs and personal goals, how those services/supports are funded, and how to access those services/supports. Training should promote a thorough understanding of all services/supports available, inclusive of all resources, services, and supports in the community. The "agency training" provided will be at the discretion of the agency (refer to directive 567-01-DD for recommended topic areas on the core curriculum attachment – some topics listed may not be applicable).

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program must have a minimum of <u>20 hours</u> of training in Service Coordination related topics during the first year of employment. **E. Prior to performing a specific job duty, newly employed Service Coordination Assistants will have training specifically related to each of their job duties and responsibilities.** **F. After the first year of employment, all Service Coordination staff must receive a minimum of 12 hours of training annually on topics related to the provision of Service Coordination services.** .	Other suggested topics of training to promote quality SC services are, but not limited to: • Agency policies and procedures • Effective Communication • Gathering Information for planning • Community Resources and Agency Interface • Time and Stress Management • Person-centered philosophy and concepts • Analyzing, Organizing, and Managing Information • Sensitivity to individual/family uniqueness • Advocacy, Negotiation, and Problem-Solving • Pertinent Legislation • Self-Advocacy and Self-Determination • Assistive Technology and AT resources • Working collaboratively with others • Documentation and Preparing Written Documents • Crisis Intervention Management • Condition Specific Information • Teamwork and Leadership • Measures of Effectiveness of Case Management • Risk Management • Healthcare Guidelines and Screening • Emergency Planning for People With Special Needs

II. Duties, Responsibilities, and Service Content (Core Job Functions)

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1. SCREENING: **A. DDSN designated Home Boards who are providers of Service Coordination services must screen and are the entry point for all people applying for SCDDSN services (except those with Traumatic Brain Injuries, Spinal Cord Injuries, or Similar Disabilities who will be screened by HASCI Information and Referral)**	SCREENING: Screening is a process where new referrals are processed by a screener who has been trained by DDSN to determine if a person is an appropriate referral for DDSN services and supports. Local DSN Board providers are the designated agencies which are the entry points for all new referrals and which appoint screeners. Screening for DDSN services begins with a referral and ends when a determination of 'screened in' or 'screened out' is made by the screener, and referral to other community resources is made, if appropriate, or Children, 2 years and 11 months or younger, must first be referred to Baby Net before a SCDDSN screening is complete.
B. Applicants for services will only be screened using the criteria contained in the SCDDSN Screening Tool.	SCREENING ENTITIES: All MR/RD and Autism screenings for residents of each county will be completed through the Home Board for that county. The Home Board is defined as the 'single point of entry' for services in each county. Private Service Coordination providers are not permitted to complete SCDDSN screenings and must direct all referrals to the applicant's Home Board. All HASCI screenings statewide are completed through the Head and Spinal Cord Injury Information & Referral Unit (HASCI I & R). All HASCI referrals should be directed to the HASCI I & R toll-free number (**1-866-867-3864)**. All PDD Waiver referrals should be directed to the PDD Waiver Intake and Referral toll free number **(1-888-576-4658)** RESIDENCY – Applicants must be legal South Carolina residents and legal U.S. citizens to be screened and considered for DDSN eligibility. (For more detailed information on determining residency,

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	please refer to the SCDDSN Screening Tool and Procedures as developed by the Consumer Assessment Team.
C. Only those trained as screeners may complete the SCDDSN Screening Tool.	SCREENER CREDENTIALS: The designation of 'trained screener' is given based on successful completion of the Consumer Assessment Team's training requirements, practice with consumer screenings and a written examination. For Screener training, contact the SCDDDSN Consumer Assessment Team.
D. If during screening, an immediate need(s) of the applicant is made known, the Screening agency must address this need(s) before completing the screening.	ADDRESS IMMEDIATE NEEDS/REFERRALS – When a screener becomes aware of an immediate need(s) of a person who is applying for DDSN services, the screener or Home Board designee will address this need(s) before completing the screening process. This can be accomplished by accessing any available resources to meet a one-time only or short-term need until eligibility for on-going DDSN services can be determined. The screener/Home Board designee can also make a referral to a non-DDSN service provider in the community to address an immediate need during the screening process.
E. If requested during screening, an application for a DDSN sponsored HCB Waiver must be completed within three working days, with the exception of HASCI Waiver requests. HASCI Waiver requests must be made within 15 working days of the request. **F. If determined during screening not to likely be eligible for services, the appeal process must be explained to the person or his/her legal guardian** **G. If determined during screening, to not likely be eligible for services, the person/legal guardian must be informed of other community**	Regardless of eligibility status, if requested, a request for slot allocation must be completed. For HASCI Waiver applications, refer to Chapter 3 of the HASCI Waiver manual, page 3-3. For MR/RD Waiver applications, refer to Chapter 3 of the MR/RD Waiver manual.

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resources or providers from who assistance can be sought. The person/legal guardian may appeal the screening and the screener has the option to move to intake even if the screening tool does not indicate that the person will likely be eligible. **H. Except for those screened by HASCI Information and Referral, appropriate information must be entered into CDSS by the screener using the designated caseload number for the chosen provider.** **I. When screened by the DSN Board, all available information must be forwarded to the chosen provider within 5 working days** **J. Appropriate information must be entered into CDSS by the chosen Service Coordination provider within 7 working days of receiving the referral.**	After screened in, the date of the choice of Service Coordination provider by the person/legal guardian is the DDSN case open date. If the chosen provider is unable to accept the referral, they will notify the Home Board or referral source and will return the file within 5 working days. The Home Board or referral source will then offer another choice of Service Coordination provider. OPEN CONSUMER DATA SUPPORT SYSTEM (CDSS) – (Please refer to the SCDDSN Screening Tool and Procedures for a listing of designated caseload numbers for all Service Coordination and Early Intervention providers.) NOTE: Screening is an administrative function and cannot be considered a reportable activity.
2. INTAKE: **A. Service Coordinator or agency designee must make contact with the applicant/legal guardian within 7 working days of receiving a referral from a screener.**	INTAKE: Activities that lead to the enrollment of a person in the service delivery system. Intake for DDSN eligibility determination begins when the screener notes the choice (made by the person/legal guardian) of Service Coordination or Early Intervention provider and establishes the case Open Date on the CDSS and ends with notification to the applicant/legal guardian of the eligibility decision, including any appeals that might be initiated.

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	Information for intake may be gathered by mail, electronic correspondence, and review of records, telephone interview or face-to-face interview. Contact will be made within 7 working days of receiving a referral from the screener to acknowledge receipt of the referral and to make arrangements for a home visit. The referral will be assigned to a caseload number upon receipt and NOT left in the "unassigned bucket" in the CDSS. SCAs may assume all intake duties provided the SC or SCS signs off on service notes reflecting intake activities.
B. The Service Coordinator or Service Coordination Assistant must complete a home visit with the applicant/legal guardian during intake.	The only exceptions for completing a home visit during intake are for applicants living out-of-state who have not yet moved to South Carolina or South Carolina residents hospitalized out-of-state. If the person/family/referral source is adamant that a home visit not be conducted, the situation must be discussed with District Office Service Coordination staff. Discussions should include sharing of information about potential needs and how safety, health, and welfare will be assured.
C. Appropriate intake forms must be provided to, explained to, and signed by applicants or their legal guardians.	REQUIRED INTAKE FORMS – The required intake forms include the following: ●**SCDDSN Service Agreement and Permission to Evaluate**—A valid, signed and dated SCDDSN Service Agreement form must be in the primary case record before a Service Coordinator may begin to provide services. ●**Release/Request of Information**—These forms are also required before a Service Coordinator can contact providers of services or request information regarding the applicant. ●**Acknowledgement of SC/EI Choice**—This form must be signed to document an applicant's choice of SC or EI provider**.** (All required intake forms must be signed by the applicant if 18 years of age or older and not adjudicated incompetent. If the applicant is under age 18 or age 18 or older and adjudicated

Standards	Guidance
	incompetent, the legal guardian must sign the intake forms. (Note: Official documentation of legal guardianship should be obtained and kept in the primary case record at all times.) New intake forms must be obtained when the person reaches age 18 and is not adjudicated incompetent, if there is a name change of the person and/or legal guardian, or if there is a change in legal guardianship. A new Service Agreement and Acknowledgement of SC/EI Choice form must be in the primary case record **within 30 days** after the person's 18th birthday (or other event that may require a new form). The previous Service Agreement will remain valid for up to these 30 days. Release/Request of Information forms will only need to be re-signed as needed or requested. If a person is physically unable to sign, then a person may have a designated person/surrogate to do so provided the file reflects this information. **Note: No service reporting can occur for a person who does not have a valid Service Agreement in the case record. Also, activities that occur during intake <u>prior</u> to getting a Service Agreement signed are not reportable.**) • **HIPAA Acknowledgment form (department needs to provide updated guidance here – there have been 2 providers who do not have a form thus far?)** • **Genetics Service Coordination Acknowledgement (if MR/RD)**
D. Social History information must be secured and documented during intake.	Social history to be documented on the Consumer Information Summary (CIS) that is provided to the CAT and/or in the service notes. Required paperwork to submit to the CAT: - Consumer Information Summary (CIS) - Substantial Functional Limitations Inventory(SFLI) – for HASCI referrals only - Medical reports/records - Psychologicals - Other information supporting diagnosis

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E. An eligibility packet must be completed and sent to the Consumer Assessment Team (CAT) in a timely manner.	COMPLETE CAT PACKET – The Service Coordinator or other agency designee will work together with the applicant/legal guardian to gather all required information to complete the intake packet for submission to the CAT team for review. The intake packet must be submitted to the CAT team in a timely manner to allow for an eligibility determination to be made within the required timeframe. (For more detailed information regarding DDSN requirements for the eligibility determination process, please refer to the most current DDSN eligibility determination procedures.
F. If eligibility is not determined within 3 months of the case open date, documentation must be available to show that the applicant was notified of the reason for delay.	TIMEFRAMES: DDSN eligibility should be pursued as quickly as possible. For those people in critical or urgent referral status, the SC/SCA must document accelerated and continuous attempts to exceed required intake timeframes. If an eligibility decision has not been made within 3 months of the case open date, the SC/SCA will discuss with the applicant/legal guardian the reasons for delay in eligibility and document the discussion in the service notes. The SC will inform the SCS for reasons in the delay and <u>will continue</u> to work with the applicant/legal guardian to complete the eligibility packet for up to an additional 3 months, unless otherwise indicated by the applicant/legal guardian. If eligibility is delayed due to the SC/SCA being unable to locate or contact the applicant/legal guardian, the SC/SCA will meet with the SCS to discuss the case and determine if intake should be extended or the case closed.
G. If eligibility has not been determined for 6 months from case open date, documentation is available to show that options were discussed with the applicant.	If eligibility is not determined within 6 months of the Open Date, the SC/SCA will discuss the reason for delay with the applicant/legal guardian, choices of further extension or case closure, and the option of re-applying if services are needed in the future. Any discussions and contacts with the applicant/legal guardian during the intake process, along with justification for any extensions, must be documented in service notes. If an extension is chosen, the Service Coordinator will notify the SCS, who will notify the Executive Director. <u>NOTE: No reporting</u>

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H. Documentation is available in the file showing the applicant was notified of the DDSN eligibility determination.	can occur for Intake beyond six months. If a request for the MR/RD or HASCI Waiver has been made for someone found not eligible for services, DDSN Program Directors should be involved regarding notification of Appeals. The Intake worker will notify the applicant of the eligibility determination and will document the notification in the file. If an applicant is eligible for services through DDSN, the person is assigned a Service Coordinator to begin the planning process. If an applicant is not found eligible for services, written notice of the eligibility decision will be provided to the applicant within five (5) working days of the provider's receipt of the the eligibility decision. The notice will be on the DDSN approved form letter and include information on the right to appeal and eligibility denial and procedures for appeal. Upon request of the applicant, the Service Coordinator must read or explain the eligibility decision and appeal procedures to the applicant if eligibility is denied. The Service Coordinator will also provide information and referral to appropriate community resources or other agencies based on the person's disability and needs.
3. NEEDS ASSESSMENT: **A. An assessment of the person's needs must:** **a. be initiated within 5 working days of the initial (intake) home visit** **b. completed prior to the initiation of the Plan** **c. be completed within 6 months of the first reported case management activity** **d. be completed at least annually**	NEEDS ASSESSMENT: Activities to obtain and review information to determine a person's personal goals and needs in order to develop an accurate and effective Support Plan. Needs assessment is based upon an evaluation of the person's environmental, economic, psycho-social, medical, etc. status. Personal observations and interviews are important elements of needs assessment, especially during home visits, other face-to-face contacts, and during contacts with providers of services/supports or with any other people involved in the person's life. SCDDSN Service Coordination Annual Assessment – Upon receiving a referral for DDSN services (after screened in), the SC/SCA will: • schedule an initial home visit for intake(the

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	only exceptions to an initial home visit is if the person/legal guardian is out of state) • begin gathering information about the person and his/her needs during the initial home visit • *initiate* an assessment of needs (preferably begin completion of the SCDDSN Service Coordination Annual Assessment) by using information obtained during the home visit to request records or otherwise begin collecting information needed for eligibility to be determined • reflect initiation of the assessment process in the service notes The intent of initiation of the assessment is that the assessment process is started/initiated, not that it be completed. Once a person becomes eligible for services, it will be required to complete the SCDDSN Service Coordination Annual Assessment prior to completing the Support Plan. The needs of a person receiving Level I Service Coordination are assessed by gathering as much information as possible in preparation for plan development. Information should be gathered from the person receiving services, family, friends, neighbors, legal guardian, caregivers, service providers and/or others who know the person or who are involved in the person's life. Assessment should be completed for each person receiving services at least annually prior to development of the Plan. Assessment may need to be completed again during the year if any major changes occur in the life of the person. Ongoing informal assessment will occur throughout the year during regular contacts to assure that a person's goals and needs are still consistent and are accurately reflected on the Plan. Health and safety issues/needs are considered non-negotiable and must be included on the Plan. IDENTIFYING/UPDATING NEEDS – Current needs may be identified during the year which may require previously identified needs to be discontinued

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	or revised. All newly identified needs, as well as previous goals/needs that are revised or discontinued must be noted on the Plan and documented in the service notes.
e. be completed when there is a crisis (crisis intervention) or when interventions are needed to address specific and identifiable problems (regular intervention)	REGULAR INTERVENTION*:* Time spent with the person/legal guardian to deal with specific and identifiable problems which require the Service Coordinator's guidance. The problem does not place the individual in jeopardy and the timeframe is not immediate. CRISIS INTERVENTION: Immediate response to specific needs which, if not met, would put the person in jeopardy. Crisis Intervention involves activities to respond to any emergency, life-threatening circumstance or health and safety issue arising in the life of the person which requires immediate assessment and resolution. Steps in addressing problem/crisis situations: • **Assessment of problem/crisis**- gather information in the event of a crisis situation, with assistance from other current providers, the person affected, family members or others involved, in order to identify the immediate problem and/or potential health and safety hazards which may affect the person. • **Addressing problem**- identify and implement steps to address the crisis situation in the best and safest way possible • **Follow-up/monitoring-** follow up to assure that all necessary actions/services were provided, and to monitor if the crisis is resolved or if any additional action or services may be required
B. Service Coordination providers must be accessible to people served and must have a system in place which allows people served to receive assistance with any crisis situation 24 hours a day, 7 days a week.	ACCESSIBILITY: If necessary, a back-up on-call system may be implemented which will allow immediate accessibility for people receiving services. People receiving services and providers should be encouraged to call 911 in the event of a medical or police emergency; however, Service Coordination

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	providers must still be accessible to provide assistance as needed. It is acceptable to have a general on-call number (beyond working hours) provided there is response to emergency calls within 24 hours. REPORTING OF ABUSE/CRITICAL INCIDENTS – When a crisis situation involves an abuse or critical incident as defined by agency standards, the Service Coordinator and/or the provider involved is responsible to complete a Report of Abuse or Critical Incident (per DDSN directive 534-22-DD). Service Coordinators will monitor any report of abuse or critical incident involving the person with the person to ensure that they are safe and well. The service notes will show that the Service Coordinator monitored and/or took appropriate actions to implement recommendations in final written reports of abuse and critical incidents.
C. At the time of eligibility determination, when transferring from Early Intervention into Service Coordination and when transferring between Level I and Level II Service Coordination, the Level I/Level II assessment must be completed within 45 days of the eligibility determination or prior to NO MORE THAN 3 working days prior to any transfers between programs or between levels of change in Service Coordination.	SERVICE COORDINATION LEVEL – In addition to assessing the person receiving services' goals and needs, the Service Coordinator must also determine the person's need for ongoing Service Coordination services. Once the person is assigned to a Service Coordination level, the level should be reviewed annually during the planning process for consumers on Level I, or at the annual contact for consumers on Level II. A person's Service Coordination level should also be reviewed when needs significantly change or when the person experiences a major life change. The Level I/Level II Service Coordination Assessment is not required to be completed at each subsequent annual review but the status must be reviewed and documentation should be included on the Plan. (Please refer to the SCDDSN Level I/Level II Service Coordination Policy) Documentation of Level I SC status is indicated on the first page of the *Support Plan*. The status conveys whether the person has been on Level I status and continuing, moved from Level II to Level I SC status, or moved from optional to Level I status.

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	Anytime a person is changing status of SC, the Level I/Level II Assessment must be completed at least within NO MORE THAN 3 working days of the status change.
4. PLANNING/PLAN DEVELOPMENT: **A. A Plan must:**	PLANNING/PLAN DEVELOPMENT: Planning will identify and document the personal goals and needs of the person receiving services and the services and supports necessary to address them. *(Planning by the Service Coordinator will be suspended if the consumer is placed on Level II Service Coordination).*
a. be developed within 45 calendar days of being determined eligible for SCDDSN services (except for non-eligible children requesting PDD Waiver services).	If a person is eligible for SCDDSN services, then a Plan must be completed within 45 calendar days from the date of eligibility. If needs have already been met or the person no longer requires Level I Service Coordination ,and this is justified by the Level I/Level II Service Coordination Assessment, the person can be placed on Level II Service Coordination within the 45 calendar days from the eligibility date.
b. be developed prior to the delivery of MR/RD Waiver, PDD Waiver, and/or HASCI Waiver services.	If a person has already requested a MR/RD, HASCI, or PDD Waiver slot and is awaiting that slot in critical/urgent status, the SC must document accelerated attempts to exceed the 45 day allowance for plan development. IF TRANSFERRING FROM AN ICF/MR, Service Coordinators will need to make every effort to begin assessment and planning prior to the move. The Support Plan must be in place prior to authorizing Waiver services. For children not eligible for DDSN services who are awaiting enrollment in the PDD Waiver, a Plan must be developed within 45 calendar days from the date the Waiver slot is allocated and before PDD Waiver services can be authorized.
c. be developed annually (must be completed every 365 days	For those receiving Level I Service Coordination, a plan must be completed within 365 calendar days of the last plan. For example, if a person's plan date is 7/31/2007, the next plan due must be completed on or prior to the 365th day from 7/31/2007, i.e. on or prior
d. be developed within 45 calendar	

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	days from date of transfer for those moving from Level II to Level I Service Coordination, or moving from Early Intervention services to Service Coordination	to 7/30/2008. . Each person/legal guardian must be offered the opportunity to meet with the Service Coordinator face-to-face for the purpose of completing the annual Plan. Documentation of the person's desires with regard to a face-to-face for plan development must be recorded in the service notes. If a plan meeting is desired, the person/legal guardian may request that others of his/her choosing be invited to this meeting. Meetings should be held at times and locations that are reasonable (within the county for which the person resides and/or the county where the chosen Service Coordination provider provides services) and convenient for all parties. Development of and writing the annual Plan is the responsibility of the Service Coordinator, as are any needed updates and reviews. The Service Coordinator will make sure updates/amendments to the Plan are completed and that any updates of social and demographic information are made in the CDSS and the file within 72 hours of notification. CHANGES TO THE PLAN – Any changes made to the Plan during the plan year must be in accordance with the current Plan procedures
e.	**be signed and dated by the Service Coordinator,**	A Plan is not valid if it is not signed and dated by a Service Coordinator (i.e. the Service Coordinator who authored the Plan). It is not necessary for Service Coordinators to sign all Plans received as a result of transfers from one provider to another or one caseworker to another.
f.	**be placed in the person's file within 10 working days of the Plan completion date**	
g.	**must include information about the person's plan for what to do in emergency situations** .	Emergency Plans must include the following components on all Plans beginning 7/1/08: a. <u>For people residing in SCDDSN sponsored residential settings</u>: Documentation on the Plan will include, but not limited to,: 1. a statement regarding the location of the detailed emergency disaster plan b. <u>For people in all other settings (including non-</u>

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	DDSN sponsored residential settings): Documentation on the Plan will include, but not limited to: 1. what plans have been made for an emergency/natural disaster or loss of primary caregiver 2. what transportation services/supports will be used and/or how the person will be transported 3. where the person will evacuate to if an evacuation is required
h. be current at all times	No services should be authorized or provided in the absence of a current Plan. Exceptions to not having a current Plan where services may be provided or authorized is State funded services for people coming out of intake, a person coming from EI to SC (45 days to have a current Plan), or people receiving Level II Service Coordination. A current Plan must be maintained in the file at all times. Payment for any services that are being provided for a person without a current/valid Plan may be subject to sanctions/recoupment when identified through quality assurance reviews. If a person has had a Facilitation meeting/services to assess life goals, needs and personal priorities, then the Service Coordinator must review and address the recommendations. Although personal goals may or may not be addressed as a formal need on the Service Coordination plan, the Service Coordinator will at least advocate for all service providers to address and incorporate personal goals into all service plans. Facilitation is not linked to the Service Coordination Plan and may be provided at any point during the Plan year. Facilitation is a separate service used to assist in identifying personal goals and priorities.
B. A copy of the completed Plan must be provided to the person or his/her legal guardian.	The person/legal guardian should participate indeveloping the Plan and have an understanding of its content. Documentation will be in the file to show the Service Coordinator has discussed the finalized plan with the person/legal guardian and that they

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	agree with its contents. A copy of the plan will be provided to the person/legal guardian after discussion of plan content occurs. Documentation that a copy of the Plan was provided to the person or legal guardian will be noted in the file. Other service providers do not need a copy of the Service Coordination Plan (e.g., they will not need a copy of the Plans created after 7/1/2007).
5. Plan Implementation: **A. Unless otherwise indicated by the Plan, actions to implement the services/interventions identified in the Plan must be taken as soon as the Plan is completed (implemented on the date the Plan is completed or on the date the Plan meeting occurred if a Plan meeting was chosen).** **B. Service Coordinators will provide timely response to areas of need when identified and must begin implementation of activities to address needs at least within 10 working days from the date of identification unless otherwise specified in the annual plan.**	A Plan is implemented when a Service Coordinator acts to identify, refer or access new services and supports, acts to develop new resources if none are currently available, or acts to maintain and coordinate services and supports currently received which address the needs of the consumer as documented in the current Plan. As the person's situation changes, the needs, services and supports identified in the Plan for the person served may also change. IDENTIFYING/DEVELOPING RESOURCES AND REFERRALS – Once the Plan is completed and approved, the Service Coordinator will assist the person receiving services/legal guardian in identifying appropriate providers for needed services and arranging for services. The Service Coordinator will advocate for developing new resources if needed services are not available. As needs are identified during planning or throughout the year, Service Coordinators will provide timely response to and assistance in meeting the need. Upon identification of a need/s, the Service Coordinator should respond immediately to and take action in addressing the need. Timely response is not considered to be the actual act of completing *all* activities in addressing needs. Timely response is defined as making contacts with the person regarding the coordination of activities in meeting needs. An initial response to the coordination of activities in addressing needs must be made within 10 working days unless otherwise specified in the Support Plan. Coordination by the Service Coordinator includes, but is not limited to:

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	A. Coordinates access to all necessary services available to people with disabilities (including services available to Medicaid recipients and available within the community) B. Assists people in obtaining all needed services identified in the Plan, including all services covered by Medicaid. C. Coordinates services from multiple agencies that are required to meet individual's needs. May attend public school meetings, community support meetings, and meetings with any organization or person on behalf of the person receiving services(if invited and notified of those meetings) D. Coordinates access to primary care physicians, local DSS programs, county health departments, and other local service providers. E. Coordinates services within local DSN programs or contracted private providers and effects transfers to appropriate services within DSN programs or contracted private providers which are indicated by the person's Plan. F. Arranges needed family support services/funds if indicated as a need in the Plan. G. Arranges/coordinates for a person's access to a primary health care provider (physician) and access to other health care providers based on a person's healthcare needs. H. Offers a choice of healthcare provider when a healthcare need is noted in the Plan. I. Authorizes services under a DDSN Home and Community based Waiver according to the implicated Waiver guidelines as indicated in the person's Plan. J. Coordinates necessary transportation to medical appointments through the county DSS and other local providers. CHOICE OF PROVIDERS – The person receiving services/legal guardian must be given a choice of all qualified providers of services and supports. It must be documented in service notes that a choice of

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	providers was offered and what the person receiving services/legal guardian's choice was. If there is only one potential provider for a particular area, the person receiving services/legal guardian must be informed and the Service Coordinator must document this discussion in a service note. Choice should be offered at a minimum of annually during plan development, any time the person receiving services or legal guardian requests a change in services or providers, or when a new need is identified. AUTHORIZING SERVICES – Once appropriate providers have been identified, and the Plan and funding have been approved, the Service Coordinator will send the appropriate authorization or referral form to the provider notifying them they are authorized to provide a particular service. For MR/RD, PPD and HASCI Waiver services, the appropriate Waiver authorization form should be used. (Refer to MR/RD, PPD, or HASCI Waiver guidelines for appropriate forms). For non-waiver services, Service Coordinators will follow guidance in the Procedures for QPL Implementation. Service authorization forms must be completed and a copy forwarded to the provider prior to the start date of services. Private Service Coordination providers will also send a copy of authorization forms to the Home Board or fiscal agency in the person's county of residence to aid in tracking the dissemination of funds. Authorization forms do not have to be redone annually unless there is a change.
C. a. At the time of annual planning, all people receiving Level I Service Coordination will be provided an estimate of the cost of services they receive. **b. At the time of annual contact, all people receiving Level II Service Coordination will be informed that an estimate of the cost of services they receive (if any) is available upon request.**	People receiving services will be provided an estimate, not actual, cost of services. The estimate of cost is based on the current array of services/supports they are receiving. Factors such as actual attendance in residential and day programs, fluctuations in use of services (such as PCA and nursing), and delays in direct billings to Medicaid make providing actual costs on a routine basis difficult. The DDSN standardized Microsoft Excel spreadsheet to compute actual costs of services is available for use or a provider may use a spreadsheet approved by DDSN Finance. The estimate of the cost of services will

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	generally be prepared by the SC with any additional cost data provided by the Finance Director of the provider. The provider can opt to have other staff prepare the cost estimate to give to the SC. Keep in mind that many Level II people (Refer to Memo dated 8/29/06 from the DDSN Director of Cost Analysis for specific instruction)
D. a. At the time of annual planning, all people receiving Level I Service Coordination will be provided information on what is and how to report incidents of abuse, neglect and exploitation. **b. At the time of annual contact, all people receiving Level II Service Coordination will be informed that abuse, neglect, and exploitation information is available upon request**	Information regarding abuse, neglect, and exploitation will be provided by Service Coordinators during annual plan development (i.e., anytime from the time the annual assessment is initiated up to the time of when the annual plan is implemented) and will explain who is a vulnerable adult, what is abuse, neglect, and exploitation and providers' phone numbers of where to report suspected abuse cases if they occur in a community setting or in a facility.
6. Monitoring/Contact:	MONITORING/CONTACT: The review and evaluation of services and supports to determine their continued appropriateness and effectiveness in meeting the needs of the consumer. Assessment of service quality, service effectiveness and satisfaction are fundamental elements of monitoring. Monitoring may occur through home visits, face-to-face contacts, mail correspondences or telephone calls with the person receiving services, legal guardian, family, natural supports and providers of services and supports received.
A. At least quarterly, the Plan must be monitored to assure: **a. Services are received and are effective** **b. person/legal guardian is satisfied** **c. that the Plan continues to be accurate** **B. The person's access to a primary health care provider and other health care providers is monitored as needed based on the person's health care needs**	**QUARTERLY PLAN REVIEW** – In order to assure the Plan continues to meet the person's current personal goals and needs, it must be continually monitored throughout the year and must be formally reviewed on a quarterly basis. One review will occur at the time of plan completion, and the others will be completed by the last day of each third month following the plan date. Plan reviews will consist of reviewing all current personal goals and needs to determine if interventions identified to meet goals/needs have been implemented, if interventions were useful and effective, and if the person receiving services/legal guardian is satisfied with the interventions/services and the provider of services. If

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C. For those on Level I Service Coordination, face-to-face contact between the Service Coordinator and the person must occur at least once every 365 days.	any changes/revisions need to occur as a result of the review, the Plan must be updated along with an explanation of why. A contact and/or review of reports/information from/ with each DSN operated/sponsored service provider must be made during each quarter.
D. For those on Level II Service Coordination, contact must be made at least annually.	People on Level II Service Coordination will not require quarterly reviews; annual contact is required for Level II recipients. Any contacts made with program providers or family in previous months during a quarter may be referenced as part of the full quarterly review at the end of the quarter without having to contact each provider or family member again.
E. The rate and intensity of monitoring/contact is determined based on the skills, abilities and resources available to the person.	**MONITORING COMPONENTS** – Monitoring of services/quarterly plan reviews should include the following components: (It is not required that each component be included for every contact, although all components should be included with each quarterly review.) -Continue to address the changing circumstances of the person, particularly those which support health and safety. -Services and supports must be monitored to assure they are implemented as agreed upon in the Support Plan and continue to be appropriate and effective. -Services and supports must be monitored to assure service quality and to assure that the person receiving the service or legal guardian continue to be satisfied with services and providers. -Services and supports must be monitored to assure they are meeting the needs of the person and that progress is being made toward meeting those needs. The *Plan* should reflect if consideration is being given to the need for monitoring in excess of the minimum requirements. This must be considered at least annually and, if additional monitoring is needed, the need must be included in Support Plan.

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	Additional monitoring may mean an increase in the frequency of the monitoring (i. e. monitoring more frequently than quarterly for some or all services/supports), an increase in the intensity of monitoring (i. e., face-to-face monitoring at regular intervals rather than monitoring by any other means) or a combination of increased frequency and intensity. When considering the need for additional monitoring, consider if circumstances such as, but not limited to, the following exist: -The person does not effectively communicate problems or concerns to others. (Does the person make needs known verbally or through sign language? Can the person indicate such things as how he or she got a bruise or how his/her money was spent?) -The person is physically dependent on others for basic care. (Does he/she have any capacity to physically protect him/herself?) -The person engages in behaviors that are mentally and physically challenging for caregivers. (e.g., hitting, spitting, kicking, etc.; name calling, taunting, cursing, etc.; extreme uncooperativeness; etc.) -The person does not have regular contact with family or friends who are not paid agency employees. (If family and friends are available, do they assist the person in decision-making or advocate on his/her behalf and in his/her best interest?) *The presence of circumstances such as these above may indicate an increased vulnerability and, therefore, indicate a need for increased monitoring.* People receiving Level I Service Coordination by definition require more intensive and ongoing Service Coordination services. People receiving Level II Service Coordination do not require an intensive level of Service Coordination involvement and, therefore, will not require routine monitoring. Note: DDSN HCB Waivers have specific monitoring

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	requirements in order to ensure continued access to Medicaid-funded services. Please refer to MR/RD, PDD and HASCI Waiver manuals/guidelines.
7. Advocacy: **A. The Service Coordinator must assure that the person's freedom of choice of providers is maintained, including choice of Service Coordination provider.**	ADVOCACY: Supporting basic human and civil rights of people served and families, assuring fair and equal access to environments and any necessary services, and assuring basic health and safety needs. Advocacy involves influencing human service systems to respond to needs or documented deficiencies in the service delivery system which includes recommending and facilitating a person's movement from one program area to another or from one agency to another and participating in other agencies' planning processes. HEALTH AND SAFETY – The Service Coordinator will regularly monitor the health and safety needs of the person receiving services by observing if the person is healthy and if the environment in which the person lives/works is sanitary and meets general and personal safety standards. As problems are identified, the Service Coordinator must advocate on behalf of the person to assure access to adequate health care and a clean and safe living environment.
B. The Service Coordinator must identify and document services or resources which do not exist in the local community and work to develop the availability of these services/supports.	QUALITY OF SERVICES – The Service Coordinator will advocate as necessary with current or potential service providers to assure the person's identified personal goals and needs are addressed, and that services are being provided to the person's satisfaction.
C. The Service Coordinator must ensure that all human and civil rights are maintained.	PEOPLE RECEIVING SERVICES RIGHTS – As necessary, the Service Coordinator will advocate on behalf of the person receiving services to assure basic human and civil rights in all areas of life including residential, vocational, legal, medical, educational, recreational, etc. EDUCATIONAL RIGHTS – The Service Coordinator will advocate on behalf of the person

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	receiving services in the educational setting, as applicable, to assure that all needs are being met and services are being provided as identified in the Individualized Education Plan (IEP). The Service Coordinator should work collaboratively and advocate with the person, legal guardian and school personnel to assure the appropriate education in the least restrictive environment. Use Pro-parent or other groups as necessary to advocate with/on behalf of the person in the educational setting.
8. Consultation/Collaboration: The Service Coordinator will consult and collaborate with all service providers, other professionals, and/or community agencies/resources as needed to assure that the person's needs are being met and that necessary services are available and are being provided.	CONSULTATION/COLLABORATION: The sharing of information and joint problem-solving with service providers and other professionals to gain a better understanding of a person's current situation and to determine the best course of action to address identified personal needs.

III. RECORD KEEPING AND DOCUMENTATION REQUIREMENTS

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1. A primary case record will be maintained for each person receiving services. **2. A. Records will include, but are not limited to, the following:** • Assessment Information • Current Plan and previous year's plan (If receiving Level I Service Coordination) • Level II Agreement and Level II Assessment (If receiving Level II Service Coordination) • Initial Social History Assessment and updates (If not available, documentation should appear in the records) • Medical information • Psychological Assessment, if applicable • IEPs, IFSPs, FSPs, if applicable • Eligibility Letter (after 1988) • Valid Service Agreement • Contact/Service Notes • HIPAA Acknowledgement • Acknowledgement of SC/EI Choice • Correspondence and any other documentation intended to support Medicaid reimbursement for Service Coordination • Legal records determining competency or determining a change in legal guardianship or documenting a legal name change, if applicable • Other documents which from time to time may be deemed essential	Case records maintained by the Service Coordinator are considered to be the person's primary case record with DDSN. Primary case records should be logically and consistently organized such that the identification of needs, referrals, follow-up, plan development and monitorship can be easily and clearly reviewed, copied, and audited. Service Coordination providers will have the flexibility to use the filing system of their choice (i.e. six-section divided files, 3-ring binders, etc.) Service notes should provide a clear/concise description of the circumstances being recorded. The contents should be current, complete, timely, and meet documentation requirements. Documentation should also permit someone unfamiliar with the person receiving services to quickly assume knowledge sufficient to provide Service Coordination, or to review the records to assure compliance with contracts, policies, standards and procedures.

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by DDSN or the state Medicaid agency **B.** For participants who are enrolled in the MR/RD, PDD or HASCI Waiver, the person's record contains the required forms as outlined by the Waiver manual.	Waiver Forms: ●Waiver enrollment and disenrollment forms ●Waiver budget information ●**ALL** Level of Care forms ●Freedom of Choice form ●Waiver Acknowledgement of Choice form ●Waiver Acknowledgement of Rights and Responsibilities form ●Waiver authorization and termination forms ●Vocational Rehabilitation letter, if receiving Supported Employment or Pre-Vocational service ●HASCI Waiver Third-party Insurance form • Other Waiver forms as required in the PDD, MR/RD, and HASCI Waiver manuals
4. The primary case record will be kept secure according to agency, DDSN and HIPAA confidentiality/privacy policies.	
5. The Service agreement must be signed and dated by the person/legal guardian who is requesting or receiving services.	A new Service Agreement must be completed when: • There is a change in guardianship • The individual reaches the age of majority (18) if he/she has not been adjudicated incompetent. The Service Coordinator must have the Service Agreement signed within 30 days after the 18th birthday. • A person is readmitted to the system if his/her's file was closed
6. Service notes must document all Service Coordination activity on behalf of the specific person represented by the primary case record. Notations will include the following: • **Name and title of contact person** • **Type of contact** • **Location of contact** • **Purpose of contact**	Multiple actions which support the same activity and which occurred on the same day may be incorporated into a single service note provided all necessary information is included and is clear to any other readers or reviewers. Activities done by the Service Coordinator such as written correspondence, completed reports and completion/updates to the Support Plan must be documented in service notes to include

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• **Intervention or services provided** • **The outcome** • **Needed follow-up**	identification in the record of any referenced documents. It is **not** necessary to document receipt of program reports, correspondence, etc. **unless** the Service Coordinator is reviewing these for the purpose of monitorship. The presence of the documents in the record itself will serve as documentation of their receipt. (Note: Service notes stating that "SC received and reviewed progress notes" will **NOT** be acceptable for reporting purposes. If progress notes are reviewed for the purpose of monitoring a service, documentation should include more details regarding progress toward goals, consumer satisfaction, etc.)
7. All service notes must be completed at the time a service or activity is rendered.	Service Coordinators are expected to complete service notes at the time a service or activity is rendered. All service notes must be filed in the record **prior** to reporting activities at the end of each month. (Providers have until the fifth working day of the following month to complete their SPLs, therefore, service notes may be filed at any time up to this date provided they are filed prior to billing.) Any notes done out of chronological order or any notes completed after the end of the month should be labeled as 'late entries' and filed according to the date they were **written**. All 'late entries' should include an explanation of why the entry is late. All service notes should also be filed in a case record prior to the record being transferred to another county or provider, or prior to any record review. TRANSFER OF FILES: When case records are transferred from one county to another county or from one Service Coordination provider to another within the same county, the following steps should be followed to prevent any disruption in services: The sending Service Coordination provider should: -Make efforts to offer choice of Service Coordination providers and get Acknowledgement of SC/EI Choice form signed (if a person

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	independently contacts/chooses another provider or any circumstances prohibit the transferring provider from doing so, the receiving provider/SC will get the Acknowledgement of SC/EI Choice form signed) -Contact receiving Service Coordination provider to inform of the transfer case that should be in the unassigned bin on CDSS , to obtain a caseload number, to discuss logistics of transferring services and providers and to set a date for transfer -Reconcile budget to close out services (county to county transfers only) -Update/change CDSS as needed -Review case record with SC Supervisor -Terminate services, if necessary, and notify all service providers -Copy the case record and maintain a copy of all records of service according to the established record retention policy (policy #368-01-DD). -Send originals of the case record with all documentation to the new Service Coordination provider. All above steps must be completed within 10 working days of the consumer's move or the agreed upon transfer date. The receiving Service Coordination provider should: -Ensure that the home board provider on the CDSS (county to county transfers only) is correct. -Notify SCDDSN Cost Analysis Division to set up a new waiver budget (waiver recipients only) -Update budget and services on the CDSS (For waiver recipients, complete new waiver budget within 2 working days of transfer) -Contact chosen providers and authorize services as necessary -Complete a face-to-face contact with the new referral within 45 days of move or agreed upon transfer date -Update or redo Plan as necessary -Organize all case record information and insert into a file.

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	Transferring of files/cases should be initiated within 10 working days of the move or transfer provided the Service Coordinator has been notified.
8. All service notes must be typed or handwritten in black or dark blue ink.	Photocopies of service notes may be placed in the primary case record temporarily, if the originals have been forwarded to DDSN and if the photocopies are legible. Service notes documenting concurrent activity on behalf of two or more people served are not acceptable. Service notes must be individualized to the specific person represented by the primary case record.
9. All service notes must be legible and kept in chronological order according to the date written.	Any notes done out of chronological order or any notes completed after the end of the month should be labeled as 'late entries' and filed according to the date they were **written**. All 'late entries' should include an explanation of why the entry is late. All 'late entries' must be filed on the date they were written, not on the date of the activity that is described in the note/s. All service notes should also be completed and filed in a case record prior to the record being transferred to another county or provider, or prior to any record review.
10. All service notes must be dated and legibly signed with the Service Coordinator's name or initials and professional title.	When a review reveals that a service note was not signed when written, the note must be signed immediately and that signature given the current date. A current service note must be written to explain the difference between the signature date and the date the note was actually written. If the activity described in the unsigned note was previously reported on the Service Provision Log (SPL), this is **NOT** considered a reporting error that must be corrected. If initials are used, a signature sheet must be maintained at the Service Coordination provider's office.
11. If a service is reported for during a given month, there must be a service note documenting the performance of a reportable activity during that month.	If no documentation is present in the record during a month in which a service is reported, this IS considered a reporting error that must be corrected. (Note: A Service Coordinator may 'back-report' for any activities previously not reported, or for any 'late-entries' completed at a later date for a period

Standards	Guidance
	of up to 12 months after the date the reportable activity actually occurred.)
12. A list of any abbreviations or symbols used in the records must be maintained.	This list must be clear as to the meaning of each abbreviation or symbol, and only abbreviations and symbols on this approved list may be used.
13. Any person(s) referenced in service notes or any supporting correspondences must be identified in each entry.	Identify person(s) in service notes by their full name and title or relationship to the person. References in service notes must be done at least one time for each entry/service note.
14. Errors in service notes are corrected appropriately.	When an error is made in a record, the Service Coordinator should clearly draw one line through the error, write "error" to the side in parentheses, enter the correction, and add the Service Coordinator's signature or initials and date. If additional explanation about the correction is appropriate, this must also be included in a service note. The information contained in the error must remain legible, and no correction fluid or erasable ink may be used.
15. The primary case record must follow a File Index as determined by the provider agency.	Purged record contents should also be maintained according to the provider agency's File Index and in close proximity to the primary case record. HASCI Waiver recipient's files must follow the HASCI Waiver index (refer to the HASCI Waiver Manual).Closed case records must be retained for a period of no less than 6 years after the end of the annual contract period. If any litigation, claims or other actions involving the records are initiated prior to the expiration of the 6 year period, the records must be retained until completion of the actions and resolution of all issues which arise from it, or until the end of the required period, whichever is later. (For more detailed information regarding record retention, please refer to the Individual Service Delivery Records Management Policy, #368-01-DD.

IV. Service Reporting

Standards	Guidance
A. Activities related to the core job functions are reported appropriately.	Reportable Service Coordination activities are related to the eight core job functions which were previously defined in Chapter 1. These core job functions are the primary activities/duties Service Coordinators perform. Activities which fall within the definition of one of these eight categories of services are the only activities Service Coordinators may report. **(Note: NONE of the core job function activities need to be reported for people receiving Level II Service Coordination, nor do activities performed by SC staff who does not meet position requirements. SC assistants may perform monitoring as long as the documentation of the monitoring is cosigned by a qualified SC.)** MONTHLY REPORTING – Service Coordinators are required to report on the Service Provision Log (SPL) after the end of each month for each person on active caseloads if there was at least one documented reportable Service Coordination activity for that person during the month. Service Coordinators will have until the fifth working day of the following month to complete their SPL information for each month. INITIAL REPORTING – Service Coordination activity may be reported on the SPL after a Service Agreement form is signed and after a case is opened on the Consumer Data Support System (CDSS). Service Coordination activity which occurs prior to opening a case on the CDSS (during screening) and prior to a signed Service Agreement is not considered reportable. SUPPORT PLAN – Service Coordination activity may be reported on the SPL only when a current Support Plan is in place or when a plan is in process according to established timeframes. .

Standards	Guidance
	DOCUMENTING ACTIVITY – Service Coordination activity may be reported on the SPL only when there is at least one service note during that month which clearly documents the nature of the reportable activity. (Note: Service Coordinators may back-report for any activities for which a 'late-entry' service note is completed for a period of up to 12 months after the date the activity actually occurred.) PERSON/APPLICANT NOT LOCATED – If a DDSN applicant or DDSN eligible person is missing and his/her whereabouts cannot be determined within 30 calendar days, a Service Coordinator must discontinue reporting activity until that person is located. (Reporting must be discontinued 30 days from the date the Service Coordinator is made aware of the person missing, not the actual date the person went missing.) SERVICE PROVIDER REPORTS – The reading or reviewing of reports from service providers in and of itself is not reportable. Service notes should document the reviewing of reports for the purpose of identifying needs or monitoring services or progress toward identified goals in order for this activity to be reportable. RTF/IMD – For people in Residential Treatment Facilities (RTF)/Institutions for Mental Disease (IMD) such as New Hope, Charter, Patrick B. Harris Psychiatric Hospital, and S.C. State Hospital, the SCDHHS case management hierarchy must be followed. (Please refer to Chapter 7 for a complete copy of the SCDHHS case management hierarchy.) Service Coordination services are limited to: (a) assuring that a placement continues to be necessary and appropriate to meet the person's needs and (b) planning for future placement. Reportable activities may include: a. Assessment of treatment or placement needs on an ongoing basis to ensure that the person continues to require the RTF/IMD level of care.

Standards	Guidance
	b. Participation in treatment planning meetings, IEP meetings or other agency (RTF/IMD) program or service planning meetings. c. Planning for future placement(s), assuring that a placement is appropriate to meet individual needs and is the least restrictive placement possible. d. Contact or consultation with other agencies or providers to assure appropriateness of a placement. e. Crisis assessment and referral services when a placement disrupts. f. Case management services which are required to maintain a person in a temporary alternative placement. RESIDENTIAL and ALTERNATIVE PLACEMENTS : There are no Service Coordination reporting restrictions (as there are for RTF/IMD placements) for individuals in DDSN residential placements and DDSN funded alternative (out-of-home) placements such as supervised independent living, high and moderate management group homes, specialized treatment services for sexual offenders, therapeutic foster care providers, and intensive crisis care. The SCDHHS case management hierarchy, however, must be followed. (Please refer to Chapter 7 for a copy of the SCDHHS case management hierarchy.) **EXAMPLES OF <u>NON-REPORTABLE</u> ACTIVITIES** A variety of 'non-Service Coordination' activities, which commonly occur in a normal work environment, may be required of a Service Coordinator or other provider agency staff, but are not reportable. These types of activities are very important in providing quality person-centered services for individuals and families, but do not fit into the definition of one of the eight core job functions which are approved through DHHS, and therefore are not reportable.

Standards	Guidance
	The following activities are not reportable on the SPL – but are administrative in nature: a. Activities on behalf of deceased individuals or their families. b. Verification of Medicaid numbers. c. Medicaid eligibility determinations and re-determinations. (Activities on behalf of TEFRA Medicaid applicants seeking ICF/MR Level of Care are not reportable as this is part of a Medicaid eligibility process. Activities to gather information for an ICF/MR Level of Care with the intention of obtaining ICF/MR placement or waiver services are reportable.) d. Transportation of individuals or family members for any purpose. (Service Coordinators may perform reportable activities, such as monitoring, while transporting and these are reportable on the SPL.) e. Attempted reportable activities which were never completed. (The attempt should be documented in service notes.) f. Review of an individual's primary case record (such as might occur when the individual is new to a caseload). g. Provision of information about an individual for administrative purposes (such as during a contractual compliance review). h. Participation in recreational or social activities with the individual or family. i. Activities rendered during court proceedings (South Carolina Family Court, General Sessions Court, or Federal Court) which are convened to address criminal charges against the individual. j. Activities with individuals in institutional settings (such as ICF/MRs, adult correctional facilities, juvenile reception and evaluation centers or correctional facilities). Planning, which is normally a reportable activity, may need to begin prior to institutional discharge, but will not be reportable in this circumstance.

Standards	Guidance
	k. The act of writing service notes. l. Completing statistical reports. m. Clerical activities such as typing, copying, faxing and filing. n. Composing form letters not personalized to the individual. o. Completing forms for DDSN Family Support funding. (However, discussion with the individual/legal guardian regarding the request and the gathering of information to support the request may be reportable.) p. Services to a hospice recipient unless a prior authorization number has been obtained from the hospice provider. q. Performing duties of a day or residential staff as a result of their unplanned absence. r. Fund-raising activities. s. General office management. t. Management of agency vehicles. u. Serving on DSN Board committees or inter-agency workgroups. v. Any activities completed during screening prior to Case Open date. w. Any activities on behalf of individuals receiving Level II Service Coordination.

V. Case Management Overlap

Standards	Guidance
A. When more than one case management provider is providing services, services must be provided in accordance with *The Medicaid Case Management Overlap and Hierarchy*	Refer to *Case Management Hierarchy Guidelines on* proceeding pages.

MEDICAID CASE MANAGEMENT OVERLAP AND HIERARCHY

These case management and hierarchy guidelines of the Department of Health and Human Services are intended to assist Service Coordinators in understanding their roles and their service reporting responsibilities when a DDSN consumer has multiple Medicaid-funded case managers.

CASE MANAGEMENT OVERLAP

Some individuals who are dually diagnosed or have complex social and/or medical problems may require services from more than one case management provider to be successfully managed and/or integrated into the community. The needs and resources of each individual may change over time as well as the need for case management services from another provider. Case management providers must work closely and cooperatively if the recipient's needs are to be adequately met and duplication of services and Medicaid payments are to be avoided. A system must exist within each case management program to assure that service providers are communicating, coordinating care and services, and adequately meeting individual needs

CASE MANAGEMENT HIERARCHY GUIDELINES

A Primary Case Manager as well as a Concurrent Care provider for each overlapping situation has been determined. The Primary Case Manager shall: a) ensure access to services, b) arrange needed care and services, c) monitor the case on an ongoing basis, d) provide crisis assessment and referral services, e) provide needed follow-up, and f) communicate (by telephone or face-to-face) regularly with other involved agencies/providers.

Concurrent Care shall be rendered to an individual in which another provider has been designated the Primary Case Manager. The Concurrent Care provider shall timely notify the Primary Case Manager about: a) changes in the individual/family's situation they have identified, b) needs, problems or progress, c) required referrals, and d) treatment/service planning meetings. The Concurrent Care provider will render different, distinctive types of services from the Primary Case Manager. Billing is restricted to specific activities.

Ancillary Service providers will render treatment related, case management-like services. Ancillary Services procedure codes have been set up for each Ancillary Services provider.

If overlap occurs, these guidelines shall be followed:

CCEDC/DSS Foster Care and DSS Adult Protective Services: CCEDC primary case manager with DSS providing concurrent care.

CCEDC/MTS: Overlap between these two programs is not permissible.

CCEDC/Sickle Cell: CCEDC primary case manager with Sickle Cell providing ancillary services.

CCEDC/DDSN Service Coordination: CCEDC primary case manager with DDSN providing concurrent care.

CCEDC/DDSN Early Intervention (EI): CCEDC primary case manager with EI providing concurrent care.

CCEDC/DMH: CCEDC primary case manager with DMH providing ancillary services.

CCEDC/DAODAS: CCEDC primary case manager with DAODAS providing ancillary services.

CCEDC/CLTC: CLTC primary case manager with CCEDC providing concurrent care.

CCEDC/SCSDB – Commission For Blind: CCEDC primary case manager with SCSDB – Commission for Blind providing concurrent care.

CCEDC/DJJ: CCEDC primary with DJJ providing concurrent care.

DDSN Service Coordination/DDSN Early Intervention: Overlap is not permissible.

DDSN/MTS: MTS primary case manager with DDSN providing concurrent care.

DDSN/DMH: DDSN primary case manager with DMH providing ancillary services.

DDSN/DAODAS: DDSN primary case manager with DAODAS providing ancillary services.

DDSN/Sickle Cell: DDSN primary case manager with Sickle Cell providing ancillary services.

DDSN/SCSDB – Commission For Blind: SCSDB – Commission for Blind primary case manager with DDSN providing concurrent care.

DDSN/CLTC: CLTC primary case manager with DDSN providing concurrent care. DDSN primary case manager for children (0 to 18) receiving CLTC Personal Care Aide Only services.

DDSN/DSS Foster Care and DSS Adult Protective Services: DDSN primary case manager with DSS providing concurrent care.

DDSN/DJJ: DDSN primary with DJJ providing concurrent care.

DDSN Early Intervention/DMH: DDSN primary case manager with DMH providing ancillary services.

DDSN Early Intervention/DAODAS: Overlap not anticipated.

DDSN Early Intervention/Sickle Cell: DDSN primary case manager with Sickle Cell providing ancillary services.

DDSN Early Intervention/SCSDB – Commission For Blind: SCSDB primary case manager with DDSN providing concurrent care. DDSN primary case manager with Commission for Blind providing concurrent care.

DDSN Early Intervention/CLTC: CLTC primary case manager with DDSN providing concurrent care. DDSN primary case manager for children (0 to 18) receiving CLTC Personal Care Aide Only services.

DDSN Early Intervention/DSS Foster Care: DDSN primary case manager with DSS providing concurrent care.

DDSN Early Intervention/DSS Adult Protective Services: Overlap is not anticipated.

DDSN Early Intervention/DJJ: Overlap not anticipated.

DDSN Early Intervention/MTS: MTS primary case manager with DDSN providing concurrent care.

DMH/MTS: MTS primary case manager with DMH providing ancillary services.

DMH/DAODAS: DMH primary case manager with DAODAS providing ancillary services for a client with a psychiatric disability and substance abuse problem. For other dually diagnosed clients, whichever agency is predominantly meeting treatment needs will be primary case manager.

DMH/Sickle Cell: Sickle Cell primary case manager with DMH providing ancillary services.

DMH/SCSDB – Commission For Blind: SCSDB – Commission for Blind primary case manager with DMH providing ancillary services.

DMH/CLTC: CLTC primary case manager with DMH providing ancillary services.

DMH/DSS Foster Care and DSS Adult Protective Services: DSS primary case manager with DMH providing ancillary services.

DMH/DJJ: DJJ primary case manager with DMH providing ancillary services.

DAODAS/Sickle Cell: Sickle Cell primary case manager with DAODAS providing ancillary services.

DAODAS/SCSDB – Commission For Blind: SCSDB – Commission for Blind primary case manager with DAODAS providing ancillary services.

DAODAS/CLTC: CLTC primary case manager with DAODAS providing ancillary services.

DAODAS/DSS Foster Care and DSS Adult Protective Services: DSS primary case manager with DAODAS providing ancillary services.

DAODAS/DJJ: DJJ primary case manager with DAODAS providing ancillary services.

DAODAS/MTS: MTS primary case manager with DAODAS providing ancillary services.

Sickle Cell/SCSDB – Commission For Blind: SCSDB – Commission for Blind primary case manager with Sickle Cell providing ancillary services.

Sickle Cell/CLTC: CLTC primary case manager with Sickle Cell providing ancillary services.

Sickle Cell/DSS Foster Care and DSS Adult Protective Services: DSS primary case manager with Sickle Cell providing ancillary services.

Sickle Cell/MTS: MTS primary case manager with Sickle Cell providing ancillary services.

Sickle Cell/DJJ: DJJ primary case manager with Sickle Cell providing ancillary services.

SCSDB – Commission for Blind/CLTC: Overlap not anticipated between SCSDB and CLTC. CLTC primary case manager with Commission for Blind providing concurrent care.

SCSDB – Commission For Blind/DSS Foster Care and DSS Adult Protective Services: SCSDB – Commission for Blind primary case manager with DSS providing concurrent care.

SCSDB – Commission For Blind/MTS: MTS primary case manager with SCSDB – Commission for Blind providing concurrent care.

SCSDB – Commission For Blind/DJJ: SCSDB primary case manager with DJJ providing concurrent care. DJJ primary case manager with Commission for Blind providing concurrent care.

CLTC/DSS Foster Care and DSS Adult Protective Services: CLTC primary case manager with DSS providing concurrent care.

CLTC/MTS: CLTC primary case manager with MTS providing concurrent care.

CLTC/DJJ: CLTC primary case manager with DJJ providing concurrent care.

DSS Foster Care/MTS: Overlap between these two programs is not permissible except that MTS may bill for attendance at Interagency Staffings.

DSS Foster Care/DJJ: DSS primary case manager with DJJ providing concurrent care.

KEY:

CCEDC = Continuum of Care for Emotionally Disturbed Children
CLTC = Community Long Term Care
DAODAS = Department of Alcohol and Other Drug Abuse Services

DDSN = Department of Disabilities and Special Needs
DJJ = Department of Juvenile Justice
DMH = Department of Mental Health
DSS = Department of Social Services
MTS = Managed Treatment Services
SCSDB = South Carolina School for the Deaf and the Blind

OTHER CRITERIA/SPECIAL RESTRICTIONS

1. Each provider shall be responsible for: a) attempting to identify during the intake process whether an applicant is already receiving case management services from another Medicaid provider and b) notifying any other involved Medicaid case management providers of an applicant's request for services.

2. Each provider must bill Medicaid according to Case Management Hierarchy Guidelines for each individual receiving case management services from another Medicaid provider.

3. Needed services should never be denied to an individual because another provider has been designated the Primary Case Manager.

4. Each provider shall timely notify other involved agencies or providers if an individual in an overlapping situation terminates their services.

EXCEPTIONS TO THE HIERARCHY/RESOLUTION PROCESS

Each provider is encouraged to resolve any exceptions to the Case Management Hierarchy at the local level. When an exception exists, these guidelines must be followed:

1. If a Concurrent Care provider or an Ancillary Services provider is predominantly meeting the treatment and service needs of the individual OR if the Primary Case Manager has failed to adequately coordinate care and services, the Concurrent Care provider or Ancillary Services provider may initiate contact with the Primary Case Manager at the local level to request a change in the Primary Case Manager. A meeting should be set up between the two agencies to discuss the feasibility of a change in the Primary Case Manager.

2. Contacts (telephone or face-to-face) between the Concurrent Care provider or Ancillary provider and the Primary Case Manager concerning a change in Primary Case Manager as well as the final determination of a Primary Case Manager must be documented in each provider's case management record. Although documentation of these activities is required, the activities are administrative and are not reimbursable by Medicaid.

3. If the local providers are unable to reach a determination of the most appropriate Primary Case Manager, the case should be referred to the appropriate state agency levels or main office for review.

4. If the state agency or main office administrators are unable to reach a determination of the most appropriate Primary Case Manager, the case should be referred to the Department of Health and Human Services for review.

5. The Department of Health and Human Services may make the determination of the most appropriate Primary Case Manager or may request that a team of other agency representatives make the determination.

6. The involved Medicaid providers will be notified within forty-five (45) days after the case is received by the Department of Health and Human Services whether a change in the primary case manager is warranted.